During the course of my treatment my doctor determined that I, _____ (Date of Birth _____), need or may need to receive a blood and/or blood product transfusion(s) for one or multiple of the following reasons:

- Anemia (low red blood cells), which causes decreased oxygen delivery to your body tissues
- Thrombocytopenia (low platelets) which causes bleeding problems
- Leukopenia (low white blood cells) which may predispose to infection or decreased immunity
- Missing plasma proteins which may cause bleeding or weakened immunity
- Other: _____

I discussed with my doctor that receiving blood and/or blood products may be lifesaving, but also has the risks of transmission of infections such as HIV, hepatitis B & C virus, and serious bacterial infections, as well as other risks, including but not limited to, allergic reactions, fevers, hives, fluid overload, destruction of the transfused cells, lung inflammation and immune disorders. I understand that blood and blood products are extensively screened for infectious agents, but no testing can absolutely prevent infection transmission, and I acknowledge that no guarantees have been given by my doctor, the hospital, any blood bank, or any person or entity as to the safety or efficacy of the blood or blood products I receive.

I understand that alternatives to receiving blood and/or blood products may be available to me and have discussed with my doctor these alternatives, including the risks and benefits of each alternative. We also discussed the likelihood of achieving my goals by receiving blood and/or blood products.

I understand that my nurse may give me the blood and/or blood products that my doctor has ordered.

I have been provided with a pamphlet that discusses in more detail the reasons for receiving blood and/or blood products, and the risks, benefits and alternatives to receiving blood and/or blood products. I have read and understand the information in the pamphlet.

I have had all my questions answered to my satisfaction and consent to receive blood and/or blood products as follows (check all that apply):

☐ For my current hospitalization.
☐ From _____ (date) to _____ (date) not to exceed 180 days.

☐ For outpatient treatment starting on _____ (date) and not to exceed 180 days from the date I signed this form.

_____	_____	_____	_____AM/PM
Patient/Legal Representative Signature	**Relationship of Legal Representative (if applicable)**	**Date**	**Time**
_____	_____	_____	_____AM/PM
Witness Signature	**Witness Name**	**Date**	**Time**

I have explained to the patient: the reasons for receiving blood and/or blood products and any reasonable alternatives, the anticipated benefits, the material risks, the likelihood of the patient achieving his/her goals, the potential problems that might occur after receiving blood and/or blood products, and the reasonably likely result of not receiving them.

_____	_____	_____	_____AM/PM
Doctor Signature	**Doctor Name**	**Date**	**Time**

TRM

TriHealth

INFORMED CONSENT FOR BLOOD AND/OR BLOOD PRODUCT TRANSFUSION

PATIENT IDENTIFICATION LABEL